
July 28, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard,
Baltimore, MD 21244-1850.

**Re: CMS-2454-IFC, Medicaid Program; Community Engagement Requirement for Certain Individuals**

Administrator Oz:

Thank you for this opportunity to provide comments on the Interim Final Rule (IFR) implementing Public Law 119-21 § 71119, which establishes community engagement requirements for certain adults who access Medicaid through the Affordable Care Act's (ACA's) Medicaid expansion.

For more than 100 years, Community Solutions has been a leader in Northeast Ohio's health and human services space. Our policy work, consulting services, and data for the public good informs decision-making, programming, and priorities across the region and statewide. We have a longstanding commitment to ensuring the Medicaid program is efficient, effective and accessible and are concerned that CMS-2454-IFC threatens these tenets.

**Definition of medical frailty does not align with the law**

Ohio was in the unique position of preparing for work requirements for the Medicaid expansion population when HR 1 went into effect in 2025. Because of this, Ohio had been in the process of developing implementation plans and was able to pivot last summer based on the new statute and the initial, limited CMS guidance issued last fall. The IFR fundamentally altered how medical frailty is determined by requiring states to assess whether a condition significantly impairs an individual's ability to comply with work and community engagement requirements. This interpretation does not align with HR 1 and

creates significant additional barriers for the most vulnerable individuals in the Medicaid expansion program.

Before the IFR was issued, Ohio Medicaid estimated that approximately 142,662 Group VIII beneficiaries would qualify as medically frail or disabled. Another 172,460 beneficiaries were expected to require additional review before Ohio could determine whether they qualified for an exemption, already met the requirements, or would need to participate in community engagement activities. Together, those populations represent more than 315,000 Ohioans, or roughly 40 percent of the entire Group VIII caseload. Even if most beneficiaries ultimately remain exempt, the potential review population is substantial, and the medical frailty definition adds further complexity to the review process.

**Documentation burden may fall on the sickest and/or hardest-to-reach enrollees**

Many Medicaid beneficiaries with cancer, serious mental illness, heart disease, HIV, multiple sclerosis, and substance use disorders are able to work because they have access to treatment and medications. The IFR raises new questions about whether serious illness alone will be sufficient to qualify for medical frailty protections. The rule also creates new uncertainty regarding individuals with substance use disorders who are considered to be in "stable recovery."

The IFR does not include any exemption for people experiencing homelessness. We would encourage CMS to create this exemption, but absent that step, additional considerations should be made for populations who are not only experiencing homelessness, but are more likely to be dealing with a physical or mental health condition.

The people most likely to qualify for medical frailty protections may also be individuals least able to navigate additional paperwork, documentation requests, and administrative reviews. If the exemption process becomes too complex, coverage losses could occur even among individuals the exemption was intended to protect.

**Health care providers put in the position of determining “ability to work”**

The IFR suggests that providers will play a much larger role in documenting medical frailty, responding to verification requests, and supporting beneficiaries through exemption determinations than they currently do, and beyond what they may be comfortable certifying. At the same time, H.R. 1 reduces retroactive Medicaid eligibility for many Group VIII beneficiaries from up to three months to one month.

Providers may need to build new workflows, documentation processes, and technology solutions to support medical frailty determinations. Electronic health records and related systems may also require modification to generate and transmit information efficiently. At

the same time, reducing retroactive eligibility from three months to one month increases the financial consequences of eligibility delays for providers and beneficiaries alike.

**Already burdened systems are met with further challenges**

The IFR language differs from states' initial interpretations of the law. The IFR appears to require more individualized determinations regarding medical frailty, verification, and compliance. States may need to revise eligibility and claims systems, rules, forms, notices, training materials, and business processes with only a few months remaining before implementation and even less time before notices are required to go out to impacted individuals.

It remains unclear how much of this work can be automated, centralized, or managed by county eligibility offices. Our local office, Cuyahoga County Job and Family Services, is expecting that significantly more interaction will be required to assess eligibility for the Medicaid expansion population, but will receive no more capacity or financial support to accommodate the changes. In addition to implementing Medicaid community engagement requirements, Ohio is also preparing for other major federal eligibility and work requirement changes. These include six-month Group VIII redeterminations, SNAP work requirement changes, eligibility system modifications, staff training, beneficiary outreach, and other implementation activities occurring on similar timelines.

These changes pose risks to both accuracy and timeliness through no fault of the county or the enrollees. It is not yet known if Ohio's existing eligibility infrastructure has sufficient capacity to implement these requirements without increasing delays, backlogs, or eligibility errors, but it is a critical issue to pose.

The Center for Community Solutions appreciates the opportunity to share its comments on the IFR and stands ready to review any changes to the final rule, with the hopes that it eases the burdens posed in the interim final rule for agencies, providers and most importantly Medicaid beneficiaries.

Respectfully submitted,

The Center for Community Solutions
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